

TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR A M	
LOUISE		BATCHELOR		Nov. 7, 1983		3:30 A M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS	
female	white	July 8, 1910		73 YRS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland	USA			Kent Co. MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Worton	at Home RFD Worton, Md.			Housewife			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS		21678	
Md.	Kent	Worton		RFD			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Grove Cleveland Elliott				Mattie Ella Ruark			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
no		213 42 0959		Emily B. Stubbs		Worton, Md. 21678	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart disease</u>							<u>5 years</u>
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>6/14/81</u> , 19 <u>83</u> , to <u>10/24</u> , 19 <u>83</u> , that (I) <u>lost</u> saw the deceased alive on <u>10/24</u> , 19 <u>83</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did not</u> (did not visit the body after death)							
22b. SIGNATURE DEGREE				22c. DATE SIGNED			
<u>Wayne D. Benjamin</u>				11/7/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Wayne D. Benjamin				Chestertown, Md. 21620			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		11/9/83		Chester Cemetery		Chestertown, Md.	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<u>John J. Wells</u>				NOV 14 1983		<u>John J. Wells</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 4.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

30460

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John Philip Chaires			2a. DATE OF DEATH MONTH DAY YEAR 11 2 83		2b. HOUR 2:00 P
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 7 7 30		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.	
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Oil
13a. STATE Md.		13b. CITY OR TOWN Rockhall	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS South Main St. 21661	
14. FATHER'S NAME FIRST MIDDLE LAST Albert Benjamin Chaires		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katie Dickerson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean 215-26-4979		17. INFORMANT ADDRESS Mrs. Ella Chaires (Same as #13.)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 5715 IMMEDIATE CAUSE (a) <u>Acute Hepatic Failure -</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cirrhosis of liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Electrolyte imbalance</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John J. Carroll</i>		DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/11/83	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 11/2/83		23c. NAME OF CEMETERY OR CREMATORY	
24. FUNERAL DIRECTOR NAME Anatomy Board		ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR NOV 28 1983	
				25b. REGISTRAR'S SIGNATURE <i>John J. Carroll</i>	

Albert	Benjamin	Chairman	Latic	South Main St.	Truck Driver	017
Yes	Korean	513-26-4378	Mrs. Ella Chines (Sons as 413.)			
Mr.	Bockhal					
Maryland	U.S.A.					
Male	White					

Removal 11/15/63

Anatomy Board

Nov 2 1963

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with forms FMS-1, Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation or disposal. Hold in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)		First <b>HOWARD</b> Middle <b>LINDEN</b> Last <b>DONOVAN JR.</b>				2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year <b>11-7-83</b> 19 <b>83</b>		2b. HOUR <b>6 a</b>	
3. SEX <b>MALE</b>	4. RACE <b>CAUC</b>	5. DATE OF BIRTH <b>8-31-15</b>	6. AGE (In years last birthday) <b>68</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year <b>11 7 83</b>				2d. HOUR <b>8 a</b>
7a. BIRTHPLACE (State or foreign country) <b>DELAWARE</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>KENT</b> Md.			
10. CITY OR TOWN OF DEATH <b>SASSAFRASS</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>AT HOME</b>		12a. USUAL OCCUPATION (Kind of work done during life or last if retired.) <b>ACCOUNTANT</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>BOOKKEEPING</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>KENT</b>		13c. CITY OR TOWN <b>SASSAFRASS</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RD BOX 35 80LTS, MD</b>	
14. FATHER'S NAME First Middle Last <b>HOWARD LINDEN DONOVAN SR.</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>ELIZABETH WOOLFORD</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>222-01-7131</b>		17. INFORMANT <b>ANNE DONOVAN WIFE</b>		ADDRESS <b>SAME</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL EXAMINER'S SIGNATURE <b>Robert W. Farr</b> NAME (Type) <b>Robert W. Farr, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11-9-83</b>			
ADDRESS (Street, city, town, or county) <b>Chestertown, MD</b>									
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>11-10-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. STEPHEN'S</b>		23d. LOCATION (City or Town) (County) (State) <b>EARLEVILLE, CECIL, MD</b>			
24. FUNERAL DIRECTOR <b>EDW. FELLOWS &amp; SON CECILTON, MD 21913</b>				25a. REC'D BY REGISTRAR <b>NOV 16 1983</b>		25b. REGISTRAR'S SIGNATURE <b>Ben J. C. [Signature]</b>			

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FOR NAME  
IN NEW YORK



RECEIVED  
JAN 10 1941  
NEW YORK  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
MEMORANDUM  
TO : SAC, NEW YORK  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]  
[The remainder of the document contains several paragraphs of text that are extremely faint and illegible due to the quality of the scan. The text appears to be a memorandum or report, possibly related to the subject mentioned in the header.]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Lula Elizabeth Gustafson			2a. DATE OF DEATH MONTH DAY YEAR 11 / 7 / 83		2b. HOUR 5:15AM
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Nov. 12, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 64	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. <del>XX</del> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.	
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Kent	13c. CITY OR TOWN Chestertown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS RFD Morgnec 21620
14. FATHER'S NAME FIRST MIDDLE LAST Christopher Conner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elva Dixon		ADDRESS RFD 21620 Chestertown, Md.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215 92 5918		17. INFORMANT Edward Gustafson	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pump failure</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 1/2 hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>Feb</u> , 19 <u>75</u> , to <u>4-7</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>11-7</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE <u>Dr. Dick M.B.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-7-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>A.C. Dick</u>		22e. ADDRESS <u>Chestertown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/10/83	23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown, Md.
24. FUNERAL DIRECTOR NAME <u>J. Wilho Wells</u>			25a. DATE REC'D. BY REGISTRAR NOV 14 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Gaird</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director's office, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) John Laws Holloway			2a. DATE OF DEATH MONTH DAY YEAR November 22, 1983		2b. HOUR 7:25a.m.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12/2/1910		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Distrb Tools		12b. KIND OF BUSINESS OR INDUSTRY owner	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. Kent Kennedyville							
14. FATHER'S NAME FIRST MIDDLE LAST John L. Holloway (Sr.)		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane MacAllen					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 03 7579		17. INFORMANT ADDRESS Deceased while living			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia - Pseudomonas</u> 4821 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) COPD			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. LOCATION STREET CITY OR TOWN COUNTY STATE		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/21</u> 19 <u>83</u> , to <u>11/22</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>11/21</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>C. Gottfried Baumann</u>		22c. DATE SIGNED 11/22/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. Gottfried Baumann		22e. ADDRESS Chestertown, Md. 21620	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Intombment		23b. DATE 11/26/83		23c. NAME OF CEMETERY OR CREMATORY Shrewsbury Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Kennedyville, Md.	
24. FUNERAL DIRECTOR NAME <u>Waller Wells</u>				25a. DATE REC'D. BY REGISTRAR NOV 28 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten notes and bleed-through from the reverse side of the page. The text is mostly illegible due to fading and bleed-through, but appears to be organized into sections or paragraphs.

Item 13e per phone 12/1/83 dad

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 30464

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
Tom Watson Johns

2a. DATE OF DEATH MONTH DAY YEAR  
11 18 83

2b. HOUR  
1:30a M

3. SEX  
Male

4. RACE  
Cauc.

5. DATE OF BIRTH MONTH DAY YEAR  
Apr. 22 1911

6. AGE (IN YEARS LAST BIRTHDAY) YRS.  
72

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
Alabama

7b. CITIZEN OF WHAT COUNTRY?  
USA

8. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
Kent MD.

10. CITY OR TOWN OF DEATH  
Chestertown

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
Kent & Queen Anne's Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
/Coal Miner

12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE  
MD

13b. COUNTY  
Kent

13c. CITY OR TOWN  
Millington

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS  
Box 40-B

14. FATHER'S NAME FIRST MIDDLE LAST  
James Robert Johns

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
Emma Johnson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  
No

16b. SOCIAL SECURITY NO.  
235-05-1515A

17. INFORMANT ADDRESS  
Zola Naomi Johns (wife)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Ca lung  
1629  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  
(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF  
(c) \_\_\_\_\_  
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  
1 year

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION  
2

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 5/25 19 73 to 11/17 19 83, that (I) (we) last saw the deceased alive on 11/17 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE  
G. C. Baumann

DEGREE  
a

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED  
11/21/83

22d. PHYSICIAN'S NAME (TYPE OR PRINT)  
G. C. Baumann

22e. ADDRESS  
Chestertown, MD 21620

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
Burial

23b. DATE  
11/21/83

23c. NAME OF CEMETERY OR CREMATORY  
Bel Air Mem. Gard.

23d. LOCATION CITY OR TOWN COUNTY STATE  
Bel Air HARTFORD MD

24. FUNERAL DIRECTOR  
Edward Fellows & Son  
Millington, MD

25. DATE REG'D. BY REGISTRAR  
NOV 28 1983

25b. REGISTRAR'S SIGNATURE  
G. C. Baumann

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

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100-100000

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100-100000-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eunice Lorraine Kirby			2a. DATE OF DEATH MONTH DAY YEAR November 11, 1983		2b. HOUR 6:20p M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 19, 1907		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 76		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.		
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Kent & Queen Anne's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary & Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Queen Anne		13c. CITY OR TOWN Church Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Harry A. Thompson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Addie Parsons					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212 10 9002		17. INFORMANT ADDRESS Bx 61A Lambert Kirby Church Hill, Md. 21623				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> 4148 DUE TO, OR AS A CONSEQUENCE OF (b) <u>MYOCARDIAL INFARCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):			
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>4/8</u> , 19 <u>83</u> , to <u>4/11</u> , 19 <u>83</u> , that (1) (we) last saw the deceased alive on <u>4/11</u> , 19 <u>83</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Virginia U. Collier</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22c. DATE SIGNED <u>4/13/83</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) VIRGINIA U. COLLIER MD	
22e. ADDRESS PO BOX 599			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/15/83		23c. NAME OF CEMETERY OR CREMATORY Church Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Church Hill, Md.	
24. FUNERAL DIRECTOR NAME J. Willis Wells				ADDRESS Chestertown, Md.		25. DATE REC'D. BY REGISTRAR NOV 17 1983	
				REGISTRAR'S SIGNATURE <u>John J. Casper</u>			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JOHN RAYMOND LUSBY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-5-83</b>			2b. HOUR <b>6<sup>55</sup> P.M.</b>					
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4-10-1887</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>94</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>KENT COUNTY MD.</b>					
10. CITY OR TOWN OF DEATH <b>CHESTERTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MAGNOLIA HALL Nsg. HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FARMER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>			
13a. STATE <b>MD.</b>			13b. COUNTY <b>KENT</b>		13c. CITY OR TOWN <b>KENNEDYVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Rt 213 21645</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>EDWARD (NMN) LUSBY</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LYDIA (NMN) JACOBS</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>220-28-0457</b>	
17. INFORMANT ADDRESS <b>HELEN L. WILLIAMS</b>			18. BIRTHPLACE <b>WORTON, MD</b>			19. SOCIAL SECURITY NO. <b>Box 279 21678</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **arteriosclerotic Cardiovascular Disease**  
4292  
DUE TO, OR AS A CONSEQUENCE OF  
(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF  
(c) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6-1</b> , 19 <b>83</b> , to <b>11-5</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>11-5</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Robert W. Farr</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/7/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT W. FARR</b>				22e. ADDRESS <b>Chesertown, Md.</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11/8/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CHESTER CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>CHESTERTOWN KENT MD.</b>	
24. FUNERAL DIRECTOR NAME <b>Wm V. Williams</b>				25. DATE REC'D BY REGISTRAR <b>NOV 10 1983</b>		25. REGISTRAR'S SIGNATURE <b>James G. Williams</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

2000  
CDI

Robert W. Taylor  
Robert W. Taylor



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PENDING. IF THE DEATH IS DUE TO A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										30467 REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) <b>Alwyn Ormsby</b>										2a. DATE KNOWN OF DEATH ESTIMATED <b>11/6/83</b>		2b. HOUR <b>5:18</b>
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4/18/1919</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. <b>64</b>	IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>	IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>	2c. DATE PRONOUNCED DEAD <b>11/6/83</b>		2d. HOUR <b>5:18</b>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York State</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Kent</b>						
10. CITY OR TOWN OF DEATH <b>Chestertown</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Kent &amp; Queen Anne Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>21628</b>				
13a. STATE <b>Md.</b>		13b. COUNTY <b>Queen Anne</b>		13c. CITY OR TOWN <b>Crumpton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>P.O. Bx # 252</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Gordon Ormsby</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Flossie Barton</b>				16. ADDRESS <b>P.O Bx 252</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR OATES) <b>WW 2</b>		17. INFORMANT <b>Maude Ormsby</b>		17b. ADDRESS <b>Woron, Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4100 IMMEDIATE CAUSE (a) Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE <b>Robert W. Farr</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>11-7-83</b>				
EXAMINER'S NAME (TYPE OR PRINT) <b>Kent Co.</b>				ADDRESS <b>Chestertown, Md. 21620</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>11/7/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Silverbrook Crematory</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Wilmington, Del.</b>		
24. FUNERAL DIRECTOR NAME <b>J. Wilho Wilho</b>				25. DATE REC'D. BY REGISTRAR <b>NOV 14 1983</b>				25b. REGISTRAR'S SIGNATURE <b>John J. Gansel</b>				

(88)

Nov 2. 1902

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Grace NMN Weller			2a. DATE OF DEATH MONTH DAY YEAR November 27, 1983		2b. HOUR 7:44 P M		
3. SEX FEMALE		4. RACE CAUC.		5. DATE OF BIRTH <del>XXXX</del> 7-7-05		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent & Queen Anne's Hosp. Inc.		12a. USUAL OCCUPATION (TYPE OF WORK, TRADE, BUSINESS, OR WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MARYLAND		13c. COUNTY C.A.		13d. CITY OR TOWN SUDLERSVILLE		13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME HOWARD		MIDDLE BOWDLE		15. MOTHER'S MAIDEN NAME AMELIA		MIDDLE McMULLEN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-34-6133		17. INFORMANT ADDRESS <del>XXXX</del> Betty Greenwood daughter same			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Opul. Edema ② Bilateral lobar pneumonia ③ Hypertension</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. LOCATION STREET CITY OR TOWN COUNTY STATE		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/23</u> , 19 <u>83</u> , to <u>11/27</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>11/27</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>KIN KAE WAN</u>		22c. DATE SIGNED <u>11/29/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KIN KAE WAN		22e. ADDRESS 216 High St, Chestertown, Md. 21620	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-1-83		23c. NAME OF CEMETERY OR CREMATORY SUDLERSVILLE CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE SUDLERSVILLE QA MD	
24. FUNERAL DIRECTOR NAME EDW. FELLOWS & SON MILLINGTON, MD ADDRESS				25a. DATE REC'D. BY REGISTRAR DEC 07 1983			
				25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>E. EGAR Williams</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 9, 1983</b>		2b. HOUR <b>6:50p M</b>
3. SEX <b>Male</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 17, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE STATE OR FOREIGN <b>S. CAROLINA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. <del>MARRIED</del> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Kent</b> MD.	
10. CITY OR TOWN OF DEATH <b>Chestertown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Kent &amp; Queen Anne's Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LABOR</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MD.</b>			13b. COUNTY <b>Kent</b>	13c. CITY OR TOWN <b>Worton</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNK</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNK</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-09-8975</b>		17. INFORMANT ADDRESS <b>MRS. Lucille RAULS R. 50 WORTON, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Myeloma</b> <b>2030</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Renal Failure</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>4-27</b> , 19 <b>69</b> , to <b>11/9</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>11/9</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Gottfried C. Baumann</i>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/14/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GOTTFRIED C. BAUMANN</b>		22e. ADDRESS <b>CHESTERTOWN, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BUR. A1</b>		23b. DATE <b>11-12-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVE CEM.</b>	
23d. LOCATION CITY OR TOWN <b>Worton</b>		COUNTY <b>Kent</b>		STATE <b>MD.</b>	
24. FUNERAL DIRECTOR NAME <i>John J. Conner</i>		ADDRESS <i>Chestertown</i>		25a. DATE REC'D. BY REGISTRAR <b>NOV 21 1983</b>	
				25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>	

BP

*[Faint, mostly illegible handwritten text on lined paper. The text appears to be a list or series of entries, possibly related to a survey or inventory. Some words are difficult to decipher due to fading and bleed-through.]*

*[Vertical stamp or marking, possibly reading "FILED" or similar.]*

*[Handwritten signature or name at the bottom of the page, possibly "P. B. B. B. B." or similar.]*